BHCS RISK MANAGEMENT QUARTERLY REPORT QUARTER 3 CY24

Occurrence Category CY24	Q3	%
ADR	1	0%
DELAY	10	3%
FALL	55	16%
HIPAAPHI	2	1%
INFECTION	3	1%
LAB	48	14%
MEDICATION	28	8%
OB DELIVERY	15	4%
PATCARE	81	24%
PATRIGHT	1	0%
PPID	0	0%
SAFETY	10	3%
SECURITY	60	18%
SKINWOUND	10	3%
SURGERY	17	5%
GRAND TOTAL	341	100%

OCCURRENCE CATEGORY CY24:

During the 3rd Quarter CY 2024, there were a total of 341 Occurrence Variance Reports, compared to 348 for the 2nd Quarter CY 2024.

This reflects a decrease of 7 or 1.02% for Q3 CY 2024.

Inpatient Falls by Category CY24	Q3
BABY/CHILD DROP	0
EASED TO FLOOR BY EMPLOYEE	5
EASED TO FLOOR BY NON EMPLOYEE	0
FOUND ON FLOOR	10
FROM BED	1
FROM BEDSIDE COMMODE	0
FROM CHAIR	0
FROM EQUIPMENT, i.e. stretcher, table, etc.	0
FROM TOILET	1
PATIENT STATES	1
TRIP	0
WHILE AMBULATING	3
GRAND TOTAL	21

INPATIENT FALLS BY CATEGORY CY24:

During the 3rd Quarter CY 2024, there were 21 Inpatient Falls. This reflects an increase of 2 or 5% from 19 reported in Q2 CY 2024.

There was 0 MAJOR injury, 1 Moderate, 6 MINOR injury and 14 with NO injuries.

OB DELIVERY CY24	Q3
EMERGENCY C-SECTION >30 MIN	0
FETAL DISTRESS	0
FETAL/MATERNAL DEMISE	0
MATERNAL COMPLICATIONS	0
MATERNAL TRANSFER TO HIGHER LEVEL OF CARE	1
NEONATAL COMPLICATIONS - Apgar <5 @5 min	1
POSTPARTHUM HEMORRHAGE	7
RN ATTENDED DELIVERY (0 event >30 mins Delay)	4
SHOULDER DYSTOSIA	2
GRAND TOTAL	15

OB DELIVERY CY24:

During the 3rd Quarter CY 2024, there were 15 reported occurrences, which reflects an increase of 6 or 25% from Q2 CY 2024, which reported 9.

For delays greater than 30 minutes, a referral is sent to Quality for any Quality of Care concerns.

Maternal Complications are referred and reviewed by Quality Management/Peer Review for Quality of Care

HAPIs CY24	Q3
PRESSURE INJURY-ACQUIRED	1
GRAND TOTAL	1

HAPIS CY24:

During the 3rd Quarter CY 2024, there was 1 HAPI reported, which reflects a decrease of 60% from Q2 CY 2024, which reported 4.

1 Unstageable, 0- stage II decubitus, 0 stage III decubitus, and 0 DTI's.

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MEDICATION VARIANCES CY24	Q3
CONTROL DRUG CHARTING	4
CONTROL DRUG DISCREPANCY-COUNT	0
CPOE ISUUE	0
DELAYED DOSE	1
EXPIRED MEDICATION	1
EXTRA DOSE	1
IMPROPER MONITORING	1
LABELING ERROR	1
MISSING/LOST MEDICATION	0
OTHER	2
PRESCRIBER ERROR	0
PYXIS COUNT DISCREPANCY	1
PYXIS MISS FILL	2
RECONCILIATION	1
RETURN BIN PROCESS ERROR	1
SCAN FAILED	1
SELF-MEDICATING	0
UNSECURED MEDICATION	3
WRONG CONCENTRATION	0
WRONG DOSE	1
WRONG DRUG OR IV FLUID	2
WRONG FREQUENCY OR RATE	2
WRONG PATIENT	2
WRONG ROUTE	0
WRONG TIME	1
GRAND TOTAL	28

MEDICATION VARIANCES CY24:

During the 3rd Quarter CY 2024, there were 28 Medication occurrences reported, which reflects a decrease by 9 or 13.84% from Q2 CY 2024, which reported 37.

There were 5 Near Misses that were Medication related.

Medication Variances are reviewed at the Medication Safety and P&T Committees.

The Committees review for quality improvement opportunities and recommendations are addressed collectively by all Regions.

ADR CY24	Q3
ALLERGY	1
HEMATOLOGICAL/BLOOD DISORDER	0
CARDIOPULMONARY	0
GRAND TOTAL	1

ADR CY24:

During the 3rd Quarter CY 2024, there was 1 ADR reported, which reflects an increase of 100% from Q2 CY 2024, which reported 0.

SURGERY RELATED ISSUES CY24	Q3
CONSENT ISSUES	0
EXTUBATION/INTUBATION	0
POSITIONING ISSUES	1
RETAINED FOREIGN BODY	0
SPONGE/NEEDLE/INSTRUMENT ISSUES	0
STERILE FIELD CONTAMINATED	1
SURGICAL COUNT	0
SURGERY DELAY	2
SURGERY/PROCEDURE CANCELLED	8
SURGICAL COMPLICATION	2
TOOTH DAMAGED/DISLODGED	0
UNPLANNED RETURN TO OR	3
WRONG PATIENT	0
GRAND TOTAL	17

SURGERY RELATED ISSUES CY24:

During the 3rd Quarter CY 2024, there were 17 Surgery related occurrences, which reflects an increase by 2 or 6.25% from Q2 CY 2024, which reported 15.

Surgery/Procedures cancelled are tracked and trended.

SECURITY CY24	Q3
ACCESS CONTROL	0
AGGRESSIVE BEHAVIOR	0
ARREST	0
ASSAULT/BATTERY	2
CODE ASSIST	18
CODE ELOPEMENT	0
CONTRABAND	10
CRIMINAL EVENT	0
ELOPEMENT-INVOLUNTARY ADMIT (BA, vulnerable adults etc.)	1
ELOPEMENT-VOLUNTARY ADMIT (NON-VULNERABLE)	1
PROPERTY DAMAGED/MISSING	19
SECURITY PRESENCE REQUESTED	9
SMOKING ISSUES	0
THREAT OF VIOLENCE	0
TRESPASS	0
VERBAL ABUSE	0
GRAND TOTAL	60

SECURITY CY24:

During the 3rd Quarter CY 2024, there were 60 Security related occurrences, which reflects a decrease from Q2 CY 2024 which reported 70.

There were 18 Code Assist events, in Q3 CY 2024, which reflects a decrease by 8 or 18.18% from Q2 CY 2024, which reported 26.

Property Damaged/Missing is 19 in Q3 CY 2024, which reflects an increase by 7 or 22.58% from Q2 CY 2024, which reported 12.

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SAFETY CY24	Q3
BIOHAZARD EXPOSURE	0
CODE RED	1
ELEVATOR ENTRAPMENT	0
FALSE ALARM	0
SAFETY HAZARD	5
SHARPS EXPOSURE	4
GRAND TOTAL	10

SAFETY CY24:

During Q3 CY 2024, there were 10 Safety events reported, which reflects a decrease by 6 or 23.08% from Q2 CY 2024, which reported 16.

Occurrences which involve employees and LIPs are referred to Employee Health for review.

REGIONAL RISK MANAGEMENT SECTION : (MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES , SERIOUS INCIDENTS, AHCA ANNUAL REPORTAB LE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALYSIS/RCAs COMPLETED, ETC.)

BHCS Falls Safety Measures:
Our falls drill down showed most falls being bathroom related. Staff are encouraged to ensure this is addressed during their purposeful rounding.
Reinforce with staff that patient's should not be left unattended on the bedside commode.
Continue to encourage and reinforce the need for purposeful rounding
Continue to reinforce the need for thorough and proper patient assessment and handoff.
Safety Huddles every shift with staff (to review any fall risk patients and any other safety concerns)
Reinforce the need for bedside shift report
Medications reviewed by decentralized pharmacists post-fall, feedback provided and medication(s) adjusted accordingly.
All patient's receiving sedatives prior to a procedure, should be transported via stretcher, not wheelchair
Safety sitters are assigned to non compliant patients with high risk for falls
I-Care rounding should also include ensuring Fall preventative measures are in place(functional bed alarm, bed plugged in, non-skid socks, yellow bracelet, environment clutter free and no environmental hazards)
More front line staff encouraged to attend falls meeting, multidisciplinary approach
IA/RCA for each fall with a severity level >3

ACHA ANNUAL REPORTABLE EVENTS:
There were 6 ACHA Annual Reportable Events in the 3rd Quarter CY2024:
1 - Procedure Complication (3E)
84-year-old gentleman with metastatic prostate cancer was ordered a coude catheter insertion. EMR shows that O7/07/24 at 22:50, during insertion, RN encountered resistance and was unable to get any urine. Despite this, she inflated the balloon. On 07/08/24 at 03:34, she noted that there was no urine output except for a small amount of blood in the drainage tubing. She informed admitting physician who placed a consult for Urology. At 06:08, noting that there still was no urine output, she called Urologist but was unable to reach him and left a message. Around 07:00, the Urologist came to the unit and RN informed him of above. The Urologist informed her that the balloon is inflated in the urethra. She assisted him in attempting to deflate the balloon but no urine was retrieved. He was able to eventually deflate the ballon after some difficulty. The Urologist initially planned to take the patient to the OR for the placement of Foley catheter under direct vision. At 18:15, he called the patient's family with the nurse present, and informed them that he will hold off on the procedure and will reevaluate in the morning and that the Foley inserted earlier may have caused trauma so he preferred to leave it for now and reassess in the morning. On 07/09/24, at 07:30, RN followed up with Urologist and he informed her that he recommended a suprapubic catheter insertion by IR which is better in the long run because of the patients diagnosis of prostate cancer.
The ANM reviewed the steps of Foley insertion with RN and what steps to take when resistance is encountered, including not inflating the balloon and seeking immediate assistance if a Urologist is not available- the RN verbalized understanding. Clinical Education was also notified of the event and provided education to staff.

1- Pressure Injury Acquired - Unstageable Right Foot (PICU)
3-month-old male admitted with bronchiolitis due to rhinovirus infection on 7/6/24. An IV line was placed to the R foot on 7/7/24. Patient was transferred to PICU on 7/7/24 due to increased work of breathing and tachypnea needing high flow cannula. Patient had a PIV inserted by MD on 07/07/24 to right foot. PIV was not in use for 1-2 days, remained patent and intact per nursing documentation. Upon discharge, RN removed PIV dressing and foot board and found a 1 cm wound on right foot under IV dressing after the tape was discontinued. The wound appeared to be medical-device related pressure injury caused by the rub of PIV cath. The MD was notified and assessed the patient and gave an order for bacitracin 4 times day with follow up by pediatrician in 1-2 days. The parent was educated on the plan.

1- Fall - Physical Condition Change - (Pediatrics)
17 year old male was brought to the ED by EMS after having a seizure at a restaurant. According to the mother, the patient was sitting with his friends for dinner at a restaurant, when he started having generalized tonic- clonic seizure. He fell to the ground and sustained a contusion to his left forehead. The seizure episode lasted for about 1-2 minutes. Upon arrival to the ED, the patient complained of headache and chest pain. CT scan of head & EKG was done -and resulted as normal. Tylenol was administered for the headache. Neurology was consulted and patient was admitted to the pediatric floor for seizure work up with EEG and MRI brain. After arrival to the pediatric floor, patient was in the room with his mother, and they had turn the lights off when the mother noticed that he had gotten quiet and she heard him shaking and his legs were sliding off the bed. The mother called the nurse, who found the patient sitting on the side of the bed, slumped forward. She was able to prevent the patient from sliding forward, and he was lowered to the floor and a pillow placed under his head; a Rapid response was called. The seizure was described as generalized tonic clonic with oxygen desaturation, tachycardia, and pupillary dilatation noticed. The seizure was less than 2 minutes and self-resolved. No medication was given.
The patient was then placed back onto the bed. The ED physician evaluated the patient and due to the second episode of seizure within a few hours, PICU was consulted for transfer for close monitoring. Neurology was consulted, who recommended loading patient with Keppra. Patient was accepted to the PICU and was later transferred to BHMC for additional treatment due to x-ray findings (that were done) after the patient complained of bilateral shoulder pain. The bilateral shoulder x-rays showed BL anterior gleno-humeral joint with displaced fracture of right humeral head, and a T6 Compression fracture (this was later determined to be POA). He was given Toradol for the pain.
An IA was done, and it was determined that care was appropriate and the fractures were a possibility from the seizures. The staff have since been educated about the use of 4 side rails for seizure precaution patients.

1- Medication Variance - (4W)
80 year old male who presented to the ER with complaining of shortness of breath for 2 days and stated that he has end-stage renal disease and obtains hemodialysis Monday, Wednesday, and Friday. Two days ago after 3-1/2 hours of dialysis, he felt extremely short of breath with minimal exertion. He states for the last 2 days he is markedly short of breath with any activity and his Nephrologist was consulted. Patient was admitted on 08/02/2024 to the unit.
On 08/06/2024, the RN administered 100 units of Humalog insulin instead of 100 units of Heparin. This occurred because she had the Insulin and Heparin vial on her WOW (computer). She scanned the Heparin but inadvertently grabbed the Insulin vial and drew up the incorrect medication. She immediately realized what happened and escalated it to the charge nurse. The Dr was called, and orders were received to monitor the patients glucose. The MD assessed the patient and disclosed what occurred. The patient ended up receiving 3 doses of D50 throughout the rest of the shift as well as a bolus of D5W 500 ml, an additional bolus of D10 500ml. The patient remained AAOx3 and tolerated the additional meds and fluids.
It was identified that the incorrect medication was administered. Policies on medication administration, barcode scanning, proper labeling of medication were not followed (NUR-014-235). Policies on proper storage (PIP-011-210) of medication were not followed.
The nurse identified the error and reported immediately to preclude harm to the patient. Heparin and Insulin are high risk medications. Patient has an order for Heparin 5000 units/1mL SQ Q8h for VTE prophylaxis and there was no order for insulin on patient's chart. Ticket with IT was created to determine if nurse double check is turned on for heparin SQ administrations. Nursing education provided by Clinical Education, and Pharmacy updated Pyxis machines to have high risk stickers on the insulin cubies.

1- OB Event (L&D):
30 year old female patient presented to the ER complaining of contractions since 9pm and was transferred to labor and delivery department via wheel chair on 08/26/2024. Pain score 8. No vaginal bleeding and loss of fluid reported. FHT 120bpm (G1 P0, 35weeks & 5 days) EDD 09/25/2024. The patient is a private patient, so no prenatal records was available. No risk factors, medical and surgical history is negative.
During the course, the FHT became difficult to trace and measures were implemented such as positional changes, O2, & IV fluids. The doctor and hospitalist were notified simultaneously. The hospitalist ordered a STAT C-section due to difficulty detecting FHR. Patient was taken to the OR @0236 and the infant was delivered @0242.
Apgar scores 1-0,5-0,10-0,15-0 and 20-3, Weight 2320 gm 5 lb,1 oz. Infant was resuscitated for 28 minutes and had respiratory distress needing invasive mechanical ventilation and was transferred to NICU.
The infant was transferred to BHMC- Level 3 cooling. As documented in the EHR- "HIE (Hypoxic Ischemic Encephalopathy). Currently on antiepileptic drugs and sedated. EEG -is showing no brain activity, multiorgan failure, elevated liver and cardiac enzymes, oligo anuria, comatose since admission. Critically ill-with poor prognosis. Discussions about withdrawal support re-ongoing with the family."
On 08/29/2024 patient was discharged home with specific instruction for follow up care within 1-2 weeks.
On 09/06/2024- Withdrawal was done on infant.
IA was conducted and opportunities were identified (documentation components) and recommendations made. The event was sent to Quality for peer review.

BHCS RISK MANAGEMENT QUARTERLY REPORT QUARTER 3 CY24

1 - Fall- Found On Floor - (4E):
Patient is a 52year old male with history of prediabetes and brain injury on Depakote, presenting to the ER on 09/09/2024 with complaints of chest pain. Patient also has a history of vaping. Patient stated that 3 days ago he started having substernal chest pain that feels like a crushing type of pain that worsens with exertion and sometimes have difficulty sleeping due to the discomfort. Patient also noticed that he has been having SOB progressing for several weeks. No radiation of the pain, no nausea or vomiting. Denies abdominal pain. No fevers, chills or cough and denies palpitations.
In the ER, the patients troponin level was elevated and Cardiologist was called for consultation. The patient was admitted for further evaluation.
Per Cardiologist notes: "Assessment/Plan - Diagnosis: ACS (acute coronary syndrome) and NSTEMI (non-ST elevated myocardial infarction). The patient is a 52-year-old white male with a history of cocaine use admitted with chest pain, abnormal EKG and borderline positive troponin. Unable to obtain cardiac CTA today will proceed with cardiac catheterization tomorrow. Care discussed with the patient in details." The patient had cardiac Cath done on- which showed EF of 10%.
On 09/12/2024 per nursing, overnight patient was slightly agitated and pacing and refusing to keep on monitor/leads, refusing Xanax, and refusing to remain in bed. Patient had been off the monitor since 0452 due to refusal. At around 0617 patient fell and fall alert was called. Patient was responsive and able to reposition himself and answer questions appropriately. However, per nursing, at 6:22 a.m. a rapid response was called due to patient being slightly unresponsive, however no pulse was felt and a code blue was called immediately after. Patient was coded for several minutes, intubated, ROSC was achieved and the patient was taken to the ICU, where he coded again and ACLS protocol initiated. The patient remained critically ill requiring multiple vasopressors.
At around 20:03 on 09/12/2024 patient went into cardiopulmonary arrest. Rhythm- asystole. ACLS protocol was activated. However, after discussion with patient's spouse at bedside, she requested that resuscitation efforts be stopped and patient was pronounced at 20:13.

CODE 15 & RCAs:
There was 0 Code 15 reported in the 3rd Quarter CY 2024.
There was 0 RCAs in the 3rd Quarter CY 2024.

INTENSE ANALYSIS/DISCUSSION:
There were 5 Intense Analysis/Discussion in the 3rd Quarter CY 2024:
1- Lab Event - Mislabeled Specimen
1 - OB Event
1 - Baker Act Event
1 - Medication Event
Opportunities identified and implemented accordingly.

REGULATORY VISITS:
AHCA: 0